MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

THIRD PARTY LIABILITY
HEALTH INSURANCE INFORMATION

DHS Grantee Name			Date		
DHS Case Number	Co	Dist	Sec	Unit	Spec
Specialist Name	Specialist Phone Number ( )				

INSTRUCTIONS:

- Please PRINT or TYPE
- Retain a COPY in DHS Case File

Mail ORIGINAL to:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
THIRD PARTY LIABILITY DIVISION
BUREAU OF FINANCIAL MANAGEMENT
PO BOX 30479
LANSING MI 48909

FAX: (517) 346-9817

E-MAIL: TPL_Health@Michigan.Gov

- This form and other information are also available through the internet at:
  www.michigan.gov/mdch/1,1607,7-132-2945_5100-20412--,00.html
  (Access this link by visiting www.michigan.gov/mdch , click on Providers, Information For Medicaid Policy, Third Party Liability)

SECTION 1 - Policyholder #1

Policyholder #1 Information:

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name	
Social Security Number		Employer City and State	
Insurance Company Name		Group / Policy Number	Certificate / Contract Number
Service / Coverage Code (BC/BS)		Carrier ID Number	Coverage Type

Recipient Information: Include the policyholder (if applicable) and any other adults and all children covered under **Policyholder #1**.

Recipient Name (Last, First, Middle)	Recipient ID No.	Recipient Name (Last, First, Middle)	Recipient ID No.
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Recipient Name (Last, First, Middle)	Recipient ID No.	Recipient Name (Last, First, Middle)	Recipient ID No.

SECTION 2 - Policyholder #2

Policyholder #2 Information:

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name	
Social Security Number		Employer City and State	
Insurance Company Name		Group / Policy Number	Certificate / Contract Number
Service / Coverage Code (BC/BS)		Carrier ID Number	Coverage Type

Recipient Information: Include the policyholder (if applicable) and any other adults and all children covered under **Policyholder #1**.

Recipient Name (Last, First, Middle)	Recipient ID No.	Recipient Name (Last, First, Middle)	Recipient ID No.
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SECTION 3 - Insurance Cards

- Attach copies (back & front) of any insurance cards for anyone covered under either **Policyholder #1 or #2.**
- Also attach copies (back & front) of insurance cards for any additional coverages (i.e. **vision or dental**) available to those policyholders.